TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, May 13, 1896.

FRANK HARTLEY, M.D., President, in the Chair.

SARCOMA OF UPPER JAW TREATED BY COMPLETE EXCISION OF BOTH EXTERNAL CAROTIDS.

DR. R. H. M. DAWBARN presented a young woman from whom he had completely removed both external carotids for recurring sarcoma of the superior maxilla of the right side. The object was to carry out more effectively the suggestion made by Dr. Bryant a number of years ago (but of which Dr. Dawbarn was not aware when he did his first operation), to control the blood-supply of sarcomatous growths of the naso-pharyngeal region by simply tying the external carotids. It would be remembered that at a discussion which arose some months ago, Dr. Bryant remarked before this Society that when, many years ago, he suggested such ligation Dr. Sands arose and said it was a pity that a young man of Dr. Bryant's promise should make such a mistake as to think he could control a sarcomatous growth by tying off the blood-supply. But Dr. Bryant did it, and the patient is still living. The speaker believed that in some other cases Dr. Bryant had been less successful. The tumor would shrink, but as soon as the blood-supply was restored through the collateral branches it would begin to grow again. In view of this experience of Dr. Bryant's and of Dr. Dawbarn's own, as related to the Society a few months ago, he had decided to try to obtain more permanent control of the collateral circulation by entirely dissecting out and removing the external carotids instead of simply tying them. He had since done this operation eight times upon four patients; Dr. Bryant having been present on the last occasion.

The history of the case presented to-night was that, for five months before she was sent to him by Dr. Charles G. Kerley last

winter, there had been a small growth at the site of the first and second upper right bicuspid teeth and first molar. A part of this growth was cut away and was pronounced on examination by Dr. Vissman to be giant-celled sarcoma. Dr. Dawbarn removed the new growth, also all the teeth on that side, and chiselled away the alveolar process; but there was recurrence at two points inside of a month. On examination of some of the tissue Dr. Vissman again pronounced it sarcoma. Dr. Dawbarn then decided to try the plan of dissecting out the external carotids; but in the event that the tumor should continue to grow he would, of course, proceed to take out the upper jaw. If the mutilation which the latter procedure would inflict could be avoided, the patient's prospects of marriage would not be ruined, as otherwise must be the case. Thus far the result of excision of the external carotids had been complete disappearance of the recurrent growths. It was, of course, much too early to speak of ultimate results.

The eight operations had not been difficult. There had been no deaths, no after-consequences; primary union had followed in each case. In one case, while operating upon the right side, the ligature upon the occipital branch slipped off, there was a spurt of blood, and on seizing the artery hastily the artery-forceps clamped the twelfth nerve. Although the instrument was removed instantly, the nerve was crushed, so that the right half of the tongue had become atrophied. Dr. Dawbarn thought this condition would improve with time. For convenience of work the external carotid, after ligation, was divided near its origin, and this free end, as dissection proceeded, was made to dive beneath the hypoglossal nerve, and a second time beneath the stylo-hyoid and digastric muscles. Within the parotid gland the course of the carotid was freed by stretching with a pair of dressing-forceps, until by firm traction on the artery a ligature could be slipped so high as to include at one time both branches of its terminal bifurcation. The stretching of the parotid tissue with dressing-forceps avoided the partial facial paralysis which division of the seventh nerve in its substance would cause.

THE TECHNIQUE OF TEMPORARY RESECTION OF THE SKULL, WITH DEMONSTRATION OF A NEW SET OF INSTRUMENTS.

DR. W. W. VAN ARSDALE read a paper with the above title, for which see page 465.

TUBERCULAR KIDNEY.

DR. L. W. HOTCHKISS presented a kidney, removed by lumbar nephrectomy, which he believed was the seat of early tuberculosis. The woman was twenty-six years of age, gave a good previous personal and family history, was brought to the hospital February 17. On February 12 she had been seized with severe pain in the right subcostal region, and chilly sensations. The pain lasted until her admission to the hospital, five days later. The hospital note read: Patient well nourished, tongue coated, pain in right side, great prostration, constipation, temperature 105.2° F., pulse 130, respiration 23, urine negative. Physical examination: Heart and lungs negative, abdomen flaccid, no spots, some tenderness in left hypochondriac region. Diagnosis was not made in the medical ward, but he believed typhoid was at first suspected. Three days after admission the temperature returned to normal, pain disappeared, and the urine on February 22 showed a trace of albumen, specific gravity 1005, acid, no casts. February 23 it contained no albumen, epithelial, and blood cells; specific gravity 1012. On February 25 the temperature rose suddenly to 104.5° F., and the pain in the side returned. The urine on this day was 1020, acid, contained a trace of albumen, no casts. February 28 the temperature became normal, pain disappeared. March 11 the temperature again rose and pain reappeared. On the 14th pain was absent, temperature 100° F. On the 19th, thirty days after admission, there was pain and rise of temperature, which continued until the 24th. On the 28th the temperature rose again, with return of pain. The case was transferred to the surgical side, a positive diagnosis not having been made in the medical ward. Dr. Hotchkiss suspected calculus in kidney. The blood was examined; the urine was examined daily, but remained practically negative, occasionally containing a slight trace of albumen, and a few epithelial and leucocyte cells. The specific gravity varying from 1005 to 1030; no casts were ever found; urine was not examined for tubercle bacilli. On April 4 the patient had a very severe attack of pain, lasting three days, preceded by vomiting. The pain, which was in the right lumbar region, extended down the ureter, and the diagnosis was made of probable stone in the kidney. April 10 another and similar attack. An exploratory operation was undertaken April 11, lumbar incision, pelvis of the kidney easily felt, the kidney was incised, the finger introduced into the pelvis of the organ found

it empty. The kidney was quite adherent superiorly and posteriorly. It was shelled out with some difficulty. On its anterior surface was a small abscess which seemed about to perforate, and on its upper and posterior surfaces were other similar, apparently tubercular, deposits. Section through one of them showed a wedge-shaped mass which began at the apex of one of the pyramids and passed out to the cortex. This mass was hard at periphery and softening at the centre. In the centre of the organ were two or more small masses also breaking down. An examination of one of the older lesions showed, in addition to a parenchymatous nephritis, a condition which the pathologist said was very suggestive of tuberculosis, but tubercle bacilli were not found. There was no reason to suspect a pyæmic lesion. As far as could be made out, there had been no focus of septic infection. Dr. Hotchkiss thought the specimen was interesting as representing an earlier stage of tubercular infection than was often seen. The patient had made a good recovery, the constitutional and all other symptoms rapidly disappearing. Patient was discharged from hospital in a few weeks with wound entirely healed and feeling perfectly well. Urine normal.

DR. F. TILDEN BROWN said he had intended to present a pair of tuberculous kidneys, with ureters, bladder, and urethra, but owing to the condition of the specimen he showed in preference some drawings of it. The case was interesting for the reason that the man had had much tuberculosis for at least two years, but had never had any subjective symptoms. The patient was twenty-eight years old when he died, about three weeks ago; he had evidently been tuberculous since he was ten years old. At that early age he had had knee trouble, from which he recovered under rest. There had been no further difficulty until four years ago, when a tuberculous abscess of the hip-region, which the presence of scars told of, led to incisions and drainage. Two years later Dr. Brown first saw him, and found a tuberculous knee, which required excision, from which the man made a good recovery. He was about to leave the hospital, when his right testicle was discovered to be nearly destroyed by tuberculous disease: the organ was removed. Previous and subsequent to this the urine was normal by gross inspection, but microscopic examination revealed tubercle bacilli. Then the urine was drawn from the bladder with great care, in order to exclude contaminations from the posterior urethra and overflow from the seminal vesicles, but it still contained tubercle bacilli. It was voided at normal intervals, was of normal

specific gravity, contained no blood and no albumen, but showed without fail extremely few leucocytes and in them tubercle bacilli. Some months after castration the urine was again examined, with the same result. The patient went home, having made a good recovery after his operations, and for about two years considered himself well until six weeks ago, when he again entered the hospital with a high temperature, his physician believing that he had typhoid fever. His temperature was constantly about 105° F.; he remained on the medical division seven or eight days, and died of acute general miliary tuberculosis of both lungs, every part of each lung being studded with miliary tubercles. During this last illness also there were no symptoms referable to the urinary tract. Dr. Brown was naturally interested to secure the kidneys. The left one showed two lesions, the right one contained one lesion. In both organs they were originally cortical lesions as manifested by the depressed cicatrices on the surface. The lesions were in direct communication with neighboring calyces. The left ureter was slightly dilated, and showed some disease. Both seminal vesicles were cheesy, the remaining testicle and epididymis was also cheesy, but had given him no trouble.

In connection with this case Dr. Brown showed drawings from another, illustrating tuberculosis in one kidney (the left), which evidently began in the cortex from blood-infection, from whence it had spread, destroying the function of that organ, obstructing but not infecting the corresponding ureter, but the bladder had been infected, and from thence up to the other kidney (the right), the ureter and calyces of which were involved, while its cortical region was absolutely free from disease. The internal muscular structure of the bladder was studded with miliary tubercles. The mucous membrane of the organ was all but denuded, the trigonum alone having escaped. And this patch was intensely congested and its edges undermined.

ABNORMAL KIDNEY.

DR. DAWBARN presented a specimen illustrating a rare abnormality of the kidney, one which he had not seen described after some search of the literature. He had come across it while demonstrating nephrectomy on the cadaver. The other kidney was entirely normal. The specimen presented was elongated and lobulated, not reniform; it had the usual blood-vessels and nerves, but depending from it were seven tubes, varying from a fraction of an inch to an inch or more in length, opening into a sac, easily large enough to contain an

orange. It was from this sac that the ureter going to the bladder took its origin. The ureter was about normal in size except at the sac and at the bladder, where for a short distance it was a little constricted as compared with the opposite ureter; not apparently from a pathological condition, but as an abnormality. The sac was evidently what should have been the pelvis of the kidney, while the seven sinuses leading to it from the kidney were the calyces. The cadaver was that of a middle-aged negro, who did not look at all nephritic. The kidney was yet to be cut open and examined by the pathologist.

The urine of the bladder was normal; and there were no gross signs of inflammation of either of the kidneys, nor of this curious excretory apparatus.

LARGE GANGRENOUS APPENDIX WITH LARGE FÆCAL CONCRETION.

DR. HOTCHKISS presented the specimen with the following history: Mr. L., aged twenty years, first attack of appendicitis, which began with vomiting May 2, four days before the specimen was removed. There was fever, pain, and tenderness in the right side of abdomen, and other symptoms of a mild appendicitis. Dr. Hotchkiss saw the man in consultation on the third day, but it was the night of the following day before the family decided to allow an operation to be performed. Dr. Bull saw the patient with him, and agreed as to the advisability of an operation. There was deep-seated tenderness and a well-marked mass in the right side. Dr. Hotchkiss operated May 6, expecting to find localized abscess, but instead found a large, thickened, and gangrenous appendix, in which there was a fæcal concretion the size of a small bird's egg, and three smaller ones. The appendix was gangrenous beyond the point where the large concretion was wedged. The patient recovered.

TUMOR OF UPPER JAW; DIFFERENTIAL DIAGNOSIS BY SKIAGRAPHY.

DR. HOWARD LILIENTHAL presented a tumor, probably fibroma, of the upper jaw, together with pictures taken by means of the X-ray. The patient was a young woman, twenty-one years of age, who had noticed two years ago that her left middle incisor tooth in the upper jaw felt loose. No pain. Then the adjoining tooth loosened,

and there was swelling of the alveolar processes and jaw. The swelling was hard and painless. A dentist assured her that there was a tooth in the jaw which wanted to get out,—a dentigerous cyst of some kind. He punctured with a knife and said he felt a tooth. She had nothing done until another year, or two years from the time the tooth first loosened, when another dentist was seen at the wish of her family physician, who said it was some condition which demanded immediate surgical attention. He was disposed to regard it as a cyst. When Dr. Lilienthal saw the patient there was a smooth, very hard, apparently bony swelling anteriorly in left upper jaw. The incisor was pushed well down and out, away from its fellow. The swelling had been increasing rapidly the last two or three months. As the patient was a young lady, he did not like to disfigure her more than was necessary, and decided, in the event that it were a tooth cyst, to do an incomplete operation,—make an opening into the cyst, remove the tooth, try to destroy the lining of the cyst, and spare the jaw as much as possible.

He decided first to have a skiagraph taken, which was done by Mr. Frank Martin, of 110 E. Twenty-sixth Street, New York, on April 19. The plate was placed inside the patient's mouth, while the bulb throwing out the rays pointed downward from above the nose. The lips were closed. Several exposures were made, but the best result was seen in a plate exposed for nine minutes. It showed distinctly that there was no tooth within the tumor; also that there was a mass which had pushed the natural tooth to one side. Evidently it was not a bony tumor, for the mass was rarer than the adjacent bone. The surrounding bone showed darker.

Being assured that there was no tooth within the tumor, and considering the fact that there had been rapid growth the last three months, he feared to do a palliative operation, but excised the whole growth entire. It had the appearance of an osteofibroma, and has been pronounced by Dr. F. S. Mandlebaum, pathologist to Mt. Sinai Hospital, to be a fibroma.